STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155115	A. BUILDING 00 B. WING	07/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

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F0000	This visit was for the Investigation of Complaint # IN00093796. Complaint # IN00093796-Substantiated, Federal/State deficiencies related to the allegations are cited at F-282 and F-323. Survey dates: July 28 and 29, 2011 Facility number: 0048 Provider number: 155115 AIM number: 100275330 Survey team: Toni Krakowski, RN Census bed type: SNF/NF: 110 Total: 110 Census payor type: Medicare: 10 Medicaid: 80 Other: 20 Total: 110 Sample: 5 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on August 3,	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiency, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2011 by Bev Faulkner, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow the Plan of Care to aid in the prevention of falls for 1 of 5 residents reviewed for falls in a sample of 5. Resident: #F Findings include: Resident #F's clinical record was reviewed on 7/28/11 at 5:25 P.M., and indicated diagnoses of, but not limited to, depressive disorder, Alzheimer's disease, and subacute subdural hematoma. It further indicated she was admitted to the facility on 5/20/11. During initial tour of the facility on 7/28/11 at 10:30 A.M., while accompanied by LPN #4, she identified Resident #F as a fall risk who had sustained an injury as a result of a recent fall. A "Fall Risk Assessment," dated 5/20/11,	F0282	**F282 Services by Qualified Persons/Per Care Plan** It is the practice of this provider that services be provided or arranged by the facility by qualified persons in accordance with each resident' s written plan of care.***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** *Resident F:* has had no further falls. This resident's fall care plan has been thoroughly reviewed and updated to reflect her current status and needs.***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents at risk for falls have the potential to be affected by this finding and will be identified through a facility audit. This audit will include review of all fall care plans. This audit will be completed by the IDT Team. It will ensure fall care plans accurately reflect each residents needs and include resident specific interventions for fall	08/28/2011

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	indicated Resident #F had not sustained a fall within the past three months, but was considered a fall risk because of incontinence, impaired gait/balance, impaired vision, non-compliance, and confusion. RN #3 indicated in an interview on 6/29/11 at 10:15 A.M., that a bed and chair alarm had been placed on 5/22/11, prior to Resident #F sustaining any falls in the facility because of her unsteady gait. A Care Plan, dated 6/06/11, indicated, "Problem: Resident is at risk for falls due to: unsteady gait and resident is only able to stabilize with human assistance...Resident has no safety awareness...Approach: ...Non-skid footwear, check and change 2 hrs (hours); (6/13/11) Resident makes attempts to remove foot wear; unable to put back on: ensure shoes are on securely tied; (6/28/11) fall mat; (7/18/11) To observe her-frequent attempts @ standing, leaning over chair: remove res. (resident) from dining room after meals...." A Nurse's Note, dated 7/18/11 at 9:25 A.M., indicated, "Resident found on dining room floor lying on R side. Alarm sounding...N.O. (new order) received from Dr. (Name) to send Resident to ER for Eval. (evaluation)...."		prevention as identified by the IDT Team.***What measures will be put into place or what systemic changes will be made to ensure that thie deficient practice does not recur?*** A nursing in-service will be held on August 19, 2011. This in-service will include review of the facility policy titled, “Fall Management Program” and the facility policy titled, “Care Plan Review.” This in-service will also stress the importance of following established care plan interventions to prevent falls. This in-service will be conducted by the DNS or designee, and include a post-test to determine level of understanding.***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** To ensure ongoing compliance with this corrective action, the DNS or designee will be responsible for completion of the CQI Audit tool titled, “Fall Management” weekly x 4 weeks and monthly thereafter. The CQI Audit tools titled, “Care Plan Review” and “Care Plan Updating” will also be completed weekly x 4 weeks, monthly x 3 months, and quarterly thereafter. Findings will be reported to the CQI Committee for review and corrective action if needed monthly x 4 months, and continue monthly if corrective action is	

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	Review of a CT Scan Report, dated 7/18/11, indicated, Reason for exam: ER 24; Head Injury...On today's exam, there is now a left extra-axial hematoma that measures approximately 8 mm (millimeters)...." The "Fall Circumstance Report," dated 7/18/11 at 9:10 A.M., indicated, "...Resident in dining room up in w/c [wheelchair] at table...lying on R side...no shoes or socks on @ time of fall...injuries: middle of forehead near hairline 3 by 3 cm (centimeter) purple raised area, R elbow 1 cm by 1 cm skin tear...Resident diagnosis with Alzheimer's Dementia with behavioral disturbance...intervention (s) put in place...non-skid footwear, chair and bed alarm, check and change q [every] 2 hours, offer diversional activities, remove from dining room after meals...." The IDT note, dated 7/19/11, indicated, "...we will offer diversional activities. Will continue to observe and F/U as needed...." The Director of Nursing indicated in an interview on 7/29/11 at 1:30 P.M.,that Resident #F had known behaviors prior to coming to the facility. "She has poor safety awareness. Her attention span is 20-30 seconds long. She propels herself into the dining room."		required.***By what date the systemic changes will be completed?*** Compliance Date: 8/28/11.	

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	During observation of Resident #F on 7/29/11 at 2:20 P.M., she was observed in the dining room, leaning forward in her wheel chair with her elbows barely resting on her arm rests. She was sound asleep and did not respond to her name. Her wheel chair was unlocked. She was not wearing non-skid socks; she was wearing regular white cotton socks and no shoes. She and eight other residents were unsupervised in the dining room. A facility policy titled "Fall Management Program," revised March, 2010, indicated, "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls...Fall Risk Interventions:...Equipment interventions: ...low bed with floor mats...personal alarm on chair, personal alarm on bed...proper fitting shoes, gripper socks...Staff interventions: ...Anticipate care needs for confused residents...Lay down for naps between meals. Do not leave unattended in rooms and/or bathrooms if fall risk. Special activity programs for those with behaviors...." This Federal tag relates to complaint			

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	IN00093796. 3.1-35(a)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to evaluate and analyze causative factors related to falls and develop appropriate interventions to prevent a fall which resulted in a fractured femur (Resident #D) and a subdural hematoma (Resident #F). This deficient practice affected 2 of 5 residents reviewed for falls in a sample of 5. Findings include: 1. Resident #F's closed clinical record was	F0323	**F323 – Accidents and Supervision** It is the practice of this provider to ensure that the resident environment remains free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** *Resident D: Has been discharged from facility. Resident F: H*as experienced no further falls. Fall care plan has been thoroughly reviewed and	08/28/2011

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	reviewed on 7/28/11 at 5:25 P.M., and indicated diagnoses of, but not limited to, depressive disorder, Alzheimer's disease, and subacute subdural hematoma. It further indicated she was admitted to the facility on 5/20/11. During initial tour of the facility on 7/28/11 at 10:30 A.M., while accompanied by LPN #4, she identified Resident #F as a fall risk who had sustained an injury as a result of a recent fall. A "Fall Risk Assessment," dated 5/20/11, indicated Resident #F had not sustained a fall within the past three months, but was considered a fall risk because of incontinence, impaired gait/balance, impaired vision, non-compliance, and confusion. A Nurse's Note, dated 6/6/11 at 12:30 P.M., indicated, "Resident was observed to be lying on the floor, she was assisted to her w/c (wheel chair) by this unit and CNA. For intervention resident is to be checked every two hours and taken to the bathroom...." A "Fall Circumstance Report," dated 6/6/11 at 12:30 P.M., indicated the fall had taken place in the resident's room. She had been sitting on her bed prior to		updated to reflect accurate and appropriate interventions to prevent falls. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents identified as being at risk for falls have the potential to be affected by this finding and will be identified through a facility audit. This audit will include completion of a new Fall Assessment for each resident. Any resident identified as being at risk for falls will then have their falls care plan reviewed and updated to accurately reflect resident specific interventions including use of alarms, non-skid footwear, low beds, floor mats, etc. The Resident Care Sheets will then be corrected/updated to reflect these identified needs. Updates and revisions to care plans will be communicated to all caregivers. The Nurse Management Team and/or IDT Team will be responsible for completion of this audit. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** All nursing staff will be in-serviced on August 19, 2011. This in-service will be conducted by the DNS and/or designee and will include review of the facility policy titled, “Fall Management Program”. This in-service will	

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	the fall and was fully clothed with non-skid socks on. It further indicated the call light was in reach and the alarm was sounding. Nurse's Notes, dated 6/11/11, indicated, 10:20 A.M.: "Resident alert and oriented to self only. Confusion noted @ all times. Incontinent of B & B [bowel and bladder]. Ambulates with unsteady gait. Mobile via w/c-propels self. No safety awareness. Alarms on bed and w/c to alert staff when rising unassisted.... 11:05 A.M.: "...fell in dining area from w/c. Resident attempting to remove shoe. Was leaning forward and fell out of w/c. Shoe was underneath w/c. Resident landed on left side. Head hit floor. Hematoma above left eye on forehead...." The Nurse's Note indicated the doctor and family had been notified of the fall and family elected not to have resident sent to the ER (emergency room). An IDT (Interdisciplinary Team) Progress Note, dated 6/13/11, indicated, "IDT review of fall 6/11/11 at 11:05 A.M. ....Gripper socks were immediate intervention. IDT decided staff to ensure shoes on appropriately and continue to observe and F/U (follow up) as needed." A Nurse's Note, dated 6/27/11 at 10:00 P.M., indicated, "...put to bed to sleep and after a while she was found on the floor		also include review of fall prevention practices and following established care plan interventions, and a post-test to determine level of understanding. Fall Risk Assessments are completed on admission, annually, quarterly and with any significant change in condition. The DNS or Designee will be notified at time of fall to determine appropriate and immediate interventions. All falls will continue to be reviewed in the daily IDT meetings. Care plans will be updated daily based on the assessment, physician orders, and IDT review. Causative factors will be determined and fall care plans will be reviewed and updated. Any changes, new interventions or updates to the care plan and Resident Care Sheet will be communicated to all caregivers at that time.***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** To ensure ongoing compliance with this corrective action, the DNS and/or designee will be responsible for completion of the CQI Audit tool titled, “Fall Management” weekly x 4 weeks and monthly thereafter. In addition, compliance with the use of resident specific assistive devices will be monitored through routine rounds and observations. Any identified findings or trends	

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	by her bedside. Bed alarm in place, call light in place. She had a bump on her R (right) forehead...." The "Fall Circumstance Report," dated 6/27/11 at 9:45 P.M., indicated Resident #F had been toileted and put to bed and was later found on the floor in her night gown. It further indicated the floor was dry, without clutter, and the room light was not on. The immediate intervention put in place was a "blue floor mat at the side of the bed (and) non-skid socks on while in bed...." Neither the Nurse's Note or the Fall Circumstance Report indicated the bed alarm was sounding; however, an IDT note, dated 6/28/11, indicated, "Pt. (patient) alarm was sounding." Review of a CT (CAT) Scan Report, dated 6/28/11, indicated, "...Reason for exam: Head Injury...History: Head Injury. Lethargy and confusion...No subarachnoid or other intracranial hemorrhage is evident...." A Nurse's Note, dated 7/18/11 at 9:25 A.M., indicated, "Resident found on dining room floor lying on R side. Alarm sounding...N.O. [new order] received from Dr. [Name] to send Resident to ER for Eval. [evaluation]...." Review of a CT Scan Report, dated 7/18/11, indicated, Reason for exam: ER		will be reported to the CQI Committee monthlyfor review and corrective action if indicated. ***By what date the systemic changes will be completed?*** Compliance Date: 8/28/11.	

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	24; Head Injury...On today's exam, there is now a left extra-axial hematoma that measures approximately 8 mm [millimeters]...." The "Fall Circumstance Report," dated 7/18/11 at 9:10 A.M., indicated, "...Resident in dining room up in w/c at table...lying on R side...no shoes or socks on @ time of fall...injuries: Middle of forehead near hairline 3 by 3 cm [centimeter] purple raised area, R elbow 1 cm by 1 cm skin tear...Resident diagnosis with Alzheimer's Dementia with behavioral disturbance...intervention (s) put in place...non-skid footwear, chair and bed alarm, check and change q (every) 2 hours, offer diversional activities, remove from dining room after meals...." The IDT note, dated 7/19/11, indicated, "...we will offer diversional activities. Will continue to observe and F/U as needed...." RN #3 indicated in an interview on 6/29/11 at 10:15 A.M., that a bed and chair alarm had been placed on 5/22/11, prior to Resident #F sustaining any falls in the facility. Resident #F's Admission Minimum Data Set (MDS) Assessment, dated 5/31/11, indicated she had poor decision-making skills and required cues and supervision. It further indicated she needed extensive			

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	physical assistance of two persons for transferring. A Care Plan, dated 6/06/11, indicated, "Problem: Resident is at risk for falls due to: unsteady gait and resident is only able to stabilize with human assistance...Resident has no safety awareness...Approach: ...Non-skid footwear, check and change 2 hrs [hours]; (6/13/11) Resident makes attempts to remove foot wear; unable to put back on: ensure shoes are on securely tied; (6/28/11) fall mat; (7/18/11) To observe her-frequent attempts @ standing, leaning over chair: remove res.[resident] from dining room after meals...." The Director of Nursing indicated in an interview on 7/29/11 at 1:30 P.M., that Resident #F had known behaviors prior to coming to the facility. "She has poor safety awareness. Her attention span is 20-30 seconds long. She propels herself into the dining room." During an interview with Occupational Therapist #4 on 7/29/11 at 1:45 P.M., she indicated Resident #F gets tired and then leans in the chair. "When she's awake she sits nice and straight, if she gets fatigued she leans forward. Planned naps would probably benefit her."			

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	Social Service Staff #5 indicated in an interview on 7/29/11 at 2:00 P.M., "Resident #F attends activities like music and bingo. Pretty much anything that involves eating or music." During observation of Resident #F on 7/29/11 at 2:20 P.M., she was observed in the dining room, leaning forward in her wheel chair with her elbows barely resting on her arm rests. She was sound asleep and did not respond to her name. Her wheel chair was unlocked. She was not wearing non-skid socks; she was wearing regular white cotton socks and no shoes. She and eight other residents were unsupervised in the dining room. 2. Resident #D's clinical record was reviewed on 7/28/11 at 4:45 P.M., and indicated diagnoses of, but not limited to, history of left hip fracture, muscle weakness, and advanced dementia. A "Fall Circumstance Report," dated 1/6/11, indicated Resident #D sustained an unwitnessed fall on 1/6/11 at 2:00 P.M., and was found "sitting on bottom beside w/c (wheel chair) and next to bed...did not use call light for assist, got himself up out of w/c and lost his balance and landed on his bottom...What intervention (s) was put in to place to prevent another fall? Already			

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	has w/c, bed alarms, toilet program after meals. Enc. (encourage) to attend activities, be out of room, join other res. (residents) to talk or watch TV." Review of April, May, June, and July incident reports indicated Resident #D also sustained a fall on 4/28/11, 6/09/11, 6/25/11, and 7/16/11. Resident #D's "Fall Risk Assessments," dated 6/17/10 and 8/4/10, indicated he had a history of falls during the previous three months of each assessment. The most recent "Fall risk Assessment," dated July, 2011, indicated the same. All three assessments indicated Resident #D was non-compliant. An Interdisciplinary Team Progress Note (IDT), dated 6/9/11, indicated, "Fall 6/9/11 at 3:30 A.M. Found on floor in his room. Was in bed sleeping found lying on his left side in night clothes. Laceration to bridge of nose and top of right eyebrow. Immediate intervention 15 minute checks and bed alarm initiated...." Resident #D's Care Plan, initiated 12/09/10, indicated, "Problem: Res (resident) is at risk for falls d/t (due to) poor safety (sic) awareness, hx (history) of falls...doesn't use call lite...Approach: Up in wheel chair with assist... offer to			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL NURSING AND REHABILITATION CENTER	1121 E LASALLE AVE SOUTH BEND, IN46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

assist to lay down after meals...assist to toilet as needed...chair and bed alarm to alert staff of unassisted transfers...." The Care Plan also indicated hipsters to prevent injury were added on 12/10/10 and chair and bed alarms were discontinued on 5/5/11 and re-initiated again on 6/9/11 as a result of the fall.

An untitled investigation report, dated 6/25/11, indicated, "...Nurse called to resident's room found on floor R (right) side. Resident wet, bed soaked. Resident transferred [sic] from bed to chair unassisted. Alarm on w/c and bed working...found pt [patient] lying on right side in room. Pt. was attempting to transfer out of bed unassisted...." An IDT note, dated 6/27/11 (regarding fall on 6/25/11), indicated, "...Pt. was incontinent @ time of fall. Bed alarm was sounding...IDT decided to D/C [discontinue] fall mat...initiate 3 day bowel and bladder. Will continue to observe and F/U (follow up) as needed."

Nurse's Notes indicated the following: 7/16/11 at 4:00 P.M.: "Late entry Nurse called to resident's room alarm sounding off resident was lying on L (left) side on floor. Resident had gotten out of bed blood was coming from R (right) elbow skin-tear noted. Vitals were taken WNL [within normal limits]...ROM [range of

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	motion] unchanged after fall. Resident denied any c/o [complaints of] pain at this time." 7/16/11 at 4:16 P.M.: "Resident requested to lay down in bed. Nurse help assist resident to bed. Placed call light within reach asked resident to use call light and to push button showed resident how to use." 7/16/11 at 5:40 P.M.: "Alarm was sounding off resident trying to get out of bed. Nurse and CNA assisted resident to w/c [wheel chair] for dinner. No c/o @ this time." 7/16/11 at 5:45 P.M.; When resident was in dining room he c/o R leg pain...new order to send to ER [emergency room] for eval [evaluation] treatment." A "Fall Circumstance Report," dated 7/16/11 at 4:00 P.M., indicated, "Resident was in bed prior to fall. Alarm sounding when res. found on floor. Resident was toileted within one hour prior to fall...hipsters on...Resident unable to explain how fall occurred [sic]...." An IDT note, dated 7/18/11, indicated, "IDT review of fall on 7/16/11 at 4 P.M. ...Res. denied pain at time of fall....fall mat was placed at bedside. Will offer Res. diversional activities. Res. c/o R leg pain @ 5:45 P.M. and was sent to ER...Res. was admitted to hospital with R hip fracture...." A hospital History and Physical, dated 7/17/11, indicated, "Elderly male presents with hip fracture and abnormal x-rays that			

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	he may have undiagnosed metastatic cancer...He had severe anemia at one point. The patient's family decided at that point to go with comfort measures only. At one point he was in hospice. At this point, however, therefore there are no plans for further aggressive intervention other than trying to stabilize his hip fracture...." During interview with RN #3 on 7/28/11 at 5:15 P.M., she indicated Resident #D was very non-compliant with using the call light. "He didn't seem to understand he had to use the call light for assistance. He would just get up and try to transfer himself." Review of Resident #D's quarterly Minimum Data Set (MDS) Assessment, dated 5/01/11, indicated his cognition was severely impaired with a score of 3 out of 15. It also indicated he needed extensive assistance of one person for physical assistance. A facility policy titled "Fall Management Program," revised March, 2010, indicated, "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial			

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	guidelines to prevent injury related to falls...Fall Risk Interventions:...Equipment interventions: ...low bed with floor mats...personal alarm on chair, personal alarm on bed...proper fitting shoes, gripper socks...Staff interventions: ...Anticipate care needs for confused residents...Lay down for naps between meals. Do not leave unattended in rooms and/or bathrooms if fall risk. Special activity programs for those with behaviors...." This Federal tag relates to complaint IN00093796. 3.1-45(a)(2)			